NATIONAL PLANNING FOR HEALTH: STRUCTURE AND GOALS*

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NATIONAL planning for health is long overdue in this country. Indeed, the present crisis in health care is largely due to our failure to decide on national health goals and the means to accomplish them.

The fragmentation, disorganization, and gaps in our health-care system—or nonsystem—are now universally recognized. Thus far, however, we have done virtually nothing to establish national goals or national guidelines for dealing with the critical problems we face.

Let us take a look at what "health planning" has meant in the United States.

In the first place, it has been primarily local and, to a far lesser extent, statewide.

Our two planning programs in the field of health are the Comprehensive Health Planning Program and the Regional Medical Program. Both were established by federal legislation. But both are limited to encouraging *local* efforts to deal with the most serious problems—problems which reflect the failings of our *national* health care system.

I do not wish to deprecate the importance of grass-roots efforts to meet health care needs. But the problems are not in the first instance local, and the solutions cannot begin at the local level either.

It is ridiculous to expect local or even state-planning groups with no national goals or guidelines and with almost no resources to develop meaningful plans for meeting the urgent health care needs of their communities.

When I say "almost no resources" I am not referring to the funds

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for the planning agencies to hire staff, conduct research, or hold meetings. They may or may not have enough money for such purposes.

I am talking instead about the appalling lack of resources at the community level to enable people who cannot get the care they need because of inadequate income or because of unavailability or inaccessibility of services, or both, to obtain the care they need. Planning under such circumstances—and this is the situation confronting local health planners all over the country—at best deals with only peripheral problems and at worst becomes an empty academic exercise.

To put it bluntly, local goals are meaningless except in the context of national goals and both will remain pie-in-the-sky without the muscle—and that means money in the right places—to bring them to fruition.

So the first deficiency in our present health-planning activities is that, by starting at the local level, we have placed the cart before the horse. We need national goals, national guidelines, and national resources—or, to put it even more sharply, a national will and a national purpose—before health planning at the local level can be of real value.

By all odds, the lack of national purpose and national commitment is what is most wrong with health planning in the United States today. But it is by no means the whole story.

A second major shortcoming is that health planning is provider-oriented instead of being directed at meeting consumer needs. In saying this I am fully aware that the Comprehensive Health Planning Act specifically states that for a state plan for comprehensive state health planning to be approved, it must provide for establishment of a State Health Planning Advisory Council and that "a majority of the membership of such Council shall consist of representatives of consumers of health services."

That seems to be the solution to provider dominance, does it not? Require that there be a majority of consumers on the state health planning body and the consumers will run the show. Providers will play only a secondary role. However, that is not the way it works out.

Recognition in the Comprehensive Health Planning Act of the primacy of the consumer and presumably of his health care needs does represent an important step forward. I do not want to underestimate the significance of this forward step. It would seem to mean that Congress intended that in the process of planning, genuine consumer

needs and not the convenience or profit of providers or insurance carriers were to be given first consideration.

That may be what is supposed to happen, but it has not worked that way. And if you stop to think about it, there is little reason to be surprised. Despite the statutory requirement for a majority of consumer representatives, the odds have been completely against the spokesmen for consumers on Health Planning Councils, even where they have been in a nominal majority.

In the first place, there have been outright gimmicks to nullify the clear and unmistakable intent of the law.

Everyone is a consumer of health care—even doctors—but that does not mean that everyone qualifies as a bona fide consumer representative.

We all know who are legitimate representatives of consumers, who might include spokesmen of inner-city organizations, women's groups, religious faiths, trade unions, racial, ethnic, and community groups, and many others clearly identified with the needs of health care consumers.

But by what strained interpretation can doctors' wives, bankers, insurance-company representatives or even industrialists or business executives be considered genuine spokesmen for the health care consumer?

Even if such persons were sympathetic with the needs of low- and middle-income consumers, they would have almost no first-hand experience with the frustrations and hardships most workers and other consumers have experienced as they have tried to obtain decent health care for themselves and their families. Without such first-hand experience of the health-care mess, they make poor representatives of the great mass of consumers. Yet many of them sit on health-planning bodies—wolves in sheep's clothing—representing but not designated by the consumers of their areas.

A second reason why consumer representation has often failed to live up to its promise is that virtually nothing has been done to make it effective.

By and large, representatives of consumers come to health planning bodies as complete novices in the intricacies of the health care system. They know they are not getting the health care they need. They know pretty well what is lacking for themselves and their fellow workers or their neighbors. But they are not familiar with the myriad of agen-

cies, programs, and laws that have a bearing on the development of health care policy.

And the jargon of the pros—the providers and the agency staffs—is like a foreign language to the fledgling consumer representatives. Title 19, CHP, RMP, CHAMPUS, 749, 314(E) and the other numbers and initials and acronyms that so effortlessly trip off the lips of most of the people at this conference are just gibberish to the average trade union representative or League of Women Voters designee joining a health planning council.

What is needed is a realistic recognition of the handicaps most consumer representatives in health planning bodies must contend with, and a sincere determination to make sure that their participation is as effective as possible. I, for one, have sounded this note every time this question has come up in any forum, discussion, advisory body, or on any other occasion—appropriate or even inappropriate—where I have had the opportunity to raise the issue. But my pleas for a decent break for representatives of consumers in health planning have fallen on deaf ears.

If consumer representation is to be anything but an empty shell, it requires at least two types of reinforcement:

1) The budgets of health planning bodies must include funds for special orientation programs for new members of such groups, especially new consumers.

2) Representatives of consumers should have available to them on a continuing basis a consumer-oriented technical staff who will not reflect the interest of either the agency as an institution or, of course, the providers. The best precedent I can think of was the technical staff assigned to the labor and employer members of the War Labor Board during World War II and the Wage Stabilization Board during the Korean War.

Finally, it is unrealistic to expect representatives of consumers to devote their time to health planning activities if they are bogged down with details on which they are either not competent or uninterested. Neither will they put much time into such meetings if health planning does not focus on broad policy areas dealing with the real everyday needs of consumers.

But once again we come back to the same basic problem. Attempts at state or local planning for improving health care without national

goals, guidelines, and resources can prove to be only a frustrating and even embittering experience for representatives of consumers.

Before I get into the question of what the goals ought to be and the resources needed to achieve them I want to mention another way in which, it seems to me, many people are putting the cart before the horse. I am referring to those who put all their chips on such notions as creating a separate cabinet-level Department of Health and a White House-located Council of Health Advisers.

If we had a comprehensive national health program these ideas might or might not be worthwhile. But without such a program it is almost a waste of time to consider them. Nevertheless, since they come up again and again, let me briefly comment on them.

To take the second proposal first—establishing in the Office of the President a Council of Health Advisers—there is something to be said for being near the seat of the mighty. But if everybody is going to be in such close proximity to the locus of power, the value of these seats is going to decrease.

There has been talk of a Council of Social Advisers. Undoubtedly there will be proposals for similar councils for education, the environment, the cities, and many other important areas. If that happens, the Council of Health Advisers would be pretty small potatoes.

So I tend to agree with the McNerney Task Force on Medicaid and related programs in its recommendation that a Council of Health Advisers should report to the man with responsibility for health policy, the secretary of Health, Education, and Welfare (HEW).

As a member of that task force, I also agreed with its conclusion that there is nothing to be gained by breaking off health from HEW as a separate cabinet department. The Task Force's most persuasive argument was that health programs are deeply affected by activities of other HEW programs. Therefore a separate Department of Health would make coordination among such programs more difficult. To my mind, such issues are of comparatively minor importance. If they are to be considered at all, they should be looked at after we take the action needed to establish a national health program. And that brings us right back to goals and resources.

By now there is not much controversy about what should be the broad goals of national health policy. One set of objectives, not very different from others that might be cited, were recently stated by the

Citizens Board of Inquiry into Health Services for Americans headed by Professor Lester Breslow, past president of the American Public Health Association. I shall not list all of their objectives, but they included the following:

1) All Americans should receive adequate health care that has the following minimum characteristics: access to required health services and adequate organization for the delivery of health care which should include, among other requirements, no economic barriers to the receipt of care.

2) To extend the full range of health services and make them more responsive to consumers, new structures must be created, and certain existing ones more widely disseminated. Health care systems can no longer depend upon the accumulation of isolated decisions on the nature and distribution of resources and services made by individual providers irrespective of the public's needs.

3) Health care delivery systems should be organized and made accountable to the public.

4) Consumers must be able to establish goals, objectives, and priorities of the newly-structured delivery system and make them effective in the organization and delivery of health services.

5) It is the responsibility of the government, ultimately the federal government, to assure adequate health care for all Americans. Where care is inadequate, the federal government must become the residual guarantor and, if necessary, the provider of health care.

Goals such as these would have been considered quite radical and far-reaching a few years ago, but today they are the kind of objectives on which most people can agree.

But to agree on goals is one thing. To be prepared to take the action needed to achieve them is quite another. And this is where most of the health care proposals—to my mind, all except one—fall woefully short. That single exception is the National Health Security bill now before Congress.

All of the other proposals—including those of the Administration, of the American Medical Association, and of the insurance companies—are deficient in one or more of the following respects: they do not assure equal access to health care for all people; they do not provide comprehensive coverage; they do not aim at restructuring the health-care system; they do not have effective incentives for quality or effi-

ciency or controls on costs; and they depend for financing on a large number of private insurance companies.

These are precisely the gaps and defects which have made and would continue to make impossible effective national planning for health care and, therefore, planning at other levels also.

Since there will be a separate session of this conference devoted to the various legislative proposals, I shall not go into the details of the Health Security Program at this time. Let me simply remind you of its two basic purposes.

First: it is to create a system of national health security benefits that would make a broad range of quality health services available to all residents of the United States.

Second, and of equal importance: it is to bring about major improvements in the organization and delivery of health care so as to increase its availability, control its cost, and safeguard its quality.

What is important about the Health Security Program is that its enactment will provide for the first time the bricks and mortar—the goals and the resources—for building a comprehensive national health policy. And this would mean that at all levels—national, state, and local—health planning could be an effective tool instead of just an empty exercise. Moreover, the Health Security Act has specific provisions for just such a health-planning effort.

The basic charter for effective health planning is to be found in Section 102 of the Health Security Act. This provision directs the secretary, *in collaboration with state comprehensive health planning agencies, regional medical programs, and other planning agencies,* to institute a continuous process of health-service planning for the improvement, supply, and distribution of personnel and facilities, and the organization of health services.

Prior to the effective date of health benefits, the planning process must give first consideration to the most acute shortages and needs for delivery of services covered under the act. Thereafter, planning is to be focused on maximizing the continuing capability for the delivery of these services. Among other things, this section increases the authorized appropriations for state and local health planning. Comprehensive health planning agencies are directed to place emphasis on the purposes set forth in the Health Security Act in coordinating all local planning activities.

The Health Security Board is directed to give priority to improving comprehensive health services and is required in so doing to dispense financial assistance, so far as possible, in accordance with the recommendations of the appropriate health-planning agencies.

Section 54 requires approval of the health planning agency designated by the governor or the board for the construction or substantial enlargement of hospitals or professional nursing homes.

Section 134 will greatly strengthen the whole planning process. This provision, aimed at improving the coordination, availability, and quality of services, authorizes the board to require providers, as a condition of participation, to add or discontinue one or more covered services. But no direction shall be issued under this provision except upon the recommendation, or after consultation with, the appropriate state health planning agency.

These are some of the provisions in the Health Security Act which directly involve the health planning agencies. But others, which I hope will be discussed in detail here, relate to such matters as the training of health care personnel, the organization of comprehensive delivery systems, incentives for ambulatory care, and many other factors clearly tied in with health planning.

Not the least of these is the assurance of the effective participation of consumers at all levels in formulation of policies and development of programs. There will be a majority of genuine representatives of consumers on the National Advisory Council which is to assist the Health Security Board in its administration of the program as well as on regional and local advisory councils. Their participation will be effective and meaningful because the entire program will be aimed at a single objective: meeting the health care needs of consumers.

I began these remarks by saying that health planning has failed in America because we have not decided on national goals or the means to accomplish them. The Health Security Act establishes the goal.

Indeed, it is the goal of the Comprehensive Health Planning Act which has thus far been but an empty promise—"to assure comprehensive health services of high quality for every person." Health Security will provide the resources for accomplishing that long-sought goal.

Thus enactment of Health Security would for the first time make the right of quality health care for all a realistic goal for national, state, and community health planning.